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SYMPOSIUM: CLINICAL RISK AND JUDICIAL REASONING

Medical Liability Reform Crisis 2008

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Abstract The crisis of medical liability has resulted in drastic increases in insurance premiums and reduced access for patients to specialty care, particularly in areas such as obstetrics/gynecology, neurosurgery, and orthopaedic surgery. The current liability environment neither effectively compensates persons injured from medical negligence nor encourages addressing system errors to improve patient safety. The author reviews trends across the nation and reports on the efforts of an organization called "Doctors for Medical Liability Reform" to educate the public and lawmakers on the need for solutions to the chaotic process of adjudicating medical malpractice claims in the United States.

Introduction

The medical liability crisis in the United States continues. The victims of the crisis are the American people, as their access to care continues to decrease in a growing number of states and the cost of healthcare continues to increase. Patients are forced to travel greater distances and wait longer to get the care they need, as physicians change their practice patterns as a result of the lack of availability and affordability of medical liability insurance.

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There is not a crisis in malpractice, as there has not been an increased frequency of cases, but a crisis of increased judgments [11]. Between 2001 and 2002 the national average jury award in medical liability cases almost doubled from $3.9 million to $6.2 million [22]. In these verdicts, the majority of the increase was in the area of noneconomic damages, the so-called "pain and suffering" component of the jury award [19, 22]. Seventy-four percent of the suits filed against physicians are found to be meritless, with only 5.8% going to trial [19]. In 86% of the cases, the jury finds the physician not negligent, yet it costs between $24,000 and $90,000 to defend each case; in only 1% of cases is the verdict for the plaintiff [22].

A recent report in the New England Journal of Medicine showed that 40% of claims filed are groundless and that "… the system's overhead costs are exorbitant" [53]. These data suggest the current liability system neither effectively compensates persons injured from medical negligence nor encourages addressing system errors to improve patient safety.

The U.S. House of Representatives Joint Economic Committee reported that the Tort System was not better at compensating the negligently injured; that the time from injury to verdict averaged 5 years; that only 3% of victims of medical malpractice actually file a claim; that more than 80% of liability claims don't involve a negligent injury; and that more than half don't involve an injury at all [27]. It has been estimated that plaintiffs receive fewer than 28 cents out of every dollar spent on the medical liability system [42].

With greater payouts across the country, fewer insurance companies offered a medical malpractice insurance product; those still in the market began to increase policy premiums. Insurance companies project future premiums on the basis of the projected payouts or losses. In 2003

insurance companies were projecting payouts of $1.40 to $1.60 for every $1 collected [22]. This resulted in premium increases from 0% to 500% in many areas of the country over the years 1998 to 2003, and ultimately resulted in many insurance companies leaving the medical liability insurance business. St. Paul (now a part of the Travelers Co.), which insured doctors in 45 states, reported losses of over $1 billion and exited the medical malpractice business. Other companies, such as MIX Insurance, PHICO, Reliance, Farmers Insurance, and Frontier Insurance Group, soon followed suit [22].

In 2003, when medical liability reform became a top-tier priority for the members of the American Academy of Orthopaedic Surgeons and other medical professional societies, the American Medical Association determined that 13 states were in a crisis mode because of the lack of availability of physician services attributable to the medical liability crisis [7]. By June of 2004 that number had risen to 20 states, and by February 2006 Tennessee was added as the 21st state in crisis [7].

What is a crisis state? Using Tennessee as an example: Of the state's 95 counties, 81 had no residing neurosurgeon in patient care, 49 had no residing orthopaedic surgeon involved in patient care, 47 had no residing emergency room physician in patient care, and 42 had no residing OB-GYN involved in patient care. Other states, such as Hawaii, have been on the verge of crisis for several years [2].

All physicians have been affected by the medical liability crisis, but high-risk specialties have been disproportionately affected. Between 2003 and 2004, double- and triple-digit increases in medical liability premiums were seen across the country, with OB-GYNs and surgeons paying $271,241 in Dade County, Fla [39]. In 2005–2006, rates began to stabilize, but they remained exorbitantly high. Neurosurgeons in some states report paying as much as $400,000 per year for medical liability insurance [41]. Recently New York state physicians have seen great instability in their market. In 2007, New York physicians saw premium increases approaching 14%. In 2008, they are facing a $50,000 surcharge with rates increasing by 10% to 15% a year in subsequent years [57].

The victim in this crisis is the American public, which has seen its access to care affected profoundly by maldistribution of physicians and changing practice patterns. Access is affected because physicians change their practices and/or limit services. To decrease their liability risk, they eliminate high-risk procedures and stop covering the emergency room. A random survey of orthopaedic surgeons in four high-risk states (Nevada, Pennsylvania, Mississippi, and Florida) found that 58% stopped or limited their emergency room coverage; 33% no longer were doing spine surgery; 33% eliminated high-risk procedures or complicated trauma; and all noted increased referrals to academic health centers, placing greater pressure on these already overburdened centers [30, 38]. Other responses to the crisis included relocation of practices, closing practices, limiting care to office-based patients, providing less free care to poor patients, purchasing less liability coverage, and going bare (when permitted by state law) [28]. In the state of Pennsylvania, in the 5-year period preceding 2003, the state lost more than 36% of its general surgeons, 16% of its neurological surgeons, and 163 orthopaedic surgeons [10]. In June of 2003, there were only four orthopaedic surgeons in private practice in the state who were younger than 35 years of age [25].

States with a medical liability insurance crisis have difficulty recruiting physicians. In Arizona it was reported that there were only 207 doctors per 100,000 patients in 2004, well below the national average of 283 for every 100,000 patients. In addition, Arizona was graded and ranked one of the worst in the nation for emergency care and ranked 42nd for its lack of support for emergency care to meet the needs of its residents, according to the American College of Emergency Physicians [12]. The report cited low funding, a dwindling supply of physicians, and too few specialists on call among other reasons for giving the state a grade of D+ [12].

Large geographic areas of the country lack needed specialty care. The lack of availability of critical on-call specialists has resulted in the closing of many emergency rooms across the nation. In 2004, the American College of Emergency Physicians reported that 66% of emergency rooms were at risk because of the lack of availability of on-call specialist coverage. By 2006 this number had risen to 70% [40]. An Institute of Medicine Report, *The Future of Emergency Care*, showed that critical specialists are often unavailable to provide emergency trauma care as these specialists also face higher medical liability exposure than those who do not provide on-call coverage [17].

Currently, the groups most affected by the lack of access to care are women and people living in rural America. Recent reports show that one in seven OB-GYNs no longer deliver babies. In our nation's capitol, the figure is up to 40% [37]. A recent CBS Evening News Report highlighted the closing of ⅓ (14) of Philadelphia's maternity wards in the last 10 years due to the high costs of medical liability insurance [19].

A 2006 American College of Obstetrics and Gynecology survey showed 70% of OB-GYNs have made changes in their practice because of lack of available or affordable medical liability insurance, and 65% have made changes because of risk or fear of liability claims or litigation. The average age at which physicians stopped practicing obstetrics is now 48, an age once considered near the midpoint of an OB-GYN's professional career [58]. Women's health is further affected by the lack of radiologists willing to read

mammograms and decreased number of radiology residents going on to specialize in mammography. Failure to diagnose is the number one allegation in liability lawsuits [51], and radiologists are the number one group of physicians affected [20]. This is the unfortunate unintended consequence of the current liability crisis, which further impairs women's healthcare.

Future manpower needs are profoundly affected by the liability crisis. A survey found that 62% of medical residents indicated that the issue of medical liability is their top concern. Half of the responses indicated that the current environment was a factor in their specialty choice [55]. With medical students having debts as high as $200,000, specialty choice obviously plays a factor in career decisions. In 2004, only 65% of first year PGY1 slots in obstetric gynecology were filled by U.S. graduates [34]. That number remained at 67% in 2005 and 72% in the year 2006. Eighty-nine percent of OB-GYNs reported having had at least one liability claim filed against them during their professional career, with an average of 2.6 claims per OB-GYN. Furthermore, 37% have been sued for care provided during their residency.

Each year, 50% of neurosurgeons are sued [6]. In addition, ⅓ of orthopaedic surgeons, ⅓ of emergency physicians, and ⅓ of trauma surgeons are also sued each year [5]. It becomes clear why physician practice patterns change affecting access to care. Orthopaedic surgery still remains attractive to medical students, and there is no shortage of applicants to our residency training programs. The current crisis does however affect their practice locations after residency. There is great reluctance in graduating senior residents to practice in crisis states.

The Pew Charitable Trust illustrates the extent of this problem in its study of Pennsylvania, a crisis state. In a recent article, 77% of the residents in the Pennsylvania training programs who were surveyed said that they would leave Pennsylvania after their residency [38]. Unintended consequences of the current medical liability crisis are the changing doctor/patient relationship and rising healthcare costs. The medical liability crisis has resulted in increasing physician dissatisfaction with the practice of medicine. Forty percent of physicians surveyed in Pennsylvania were dissatisfied with the practice of medicine [33]. Many physicians adopt the attitude, "I now look at every patient I see as a potential lawsuit" [56]. In an article surveying medical residents across specialties in Pennsylvania, 33% of respondents felt they were less candid with their patients; 81% viewed every patient as a potential malpractice lawsuit; 67% were less eager to practice medicine than they once were; and a startling 28% regretted choosing medicine as a career [38].

The fear of lawsuits tends to drive providers to adopt behaviors that increase healthcare costs [29]. A recent survey of physicians showed that 93% reported engaging in defensive medicine with 92% reporting assurance behavior–ordering tests, particularly imaging tests, performing diagnostic procedures, and referring patients for consultation; with 42% reporting avoidance behavior–restricting practice, eliminating high-risk procedures and procedures prone to complications (trauma surgery, pediatric surgery, vaginal deliveries, cancer surgeries, spine surgeries, cranial surgery, aneurysm surgery), and avoiding patients with complex problems or patients perceived as litigious [54]. It is unfortunate, but if these assurance behaviors continue over time they become standard of care.

The liability crisis has also had a direct effect on hospital overheads. In 2003 the American Hospital Association showed that the professional liability expense per staff bed in crisis states was $11,433, compared to $4,228 in states that had medical liability reforms in place [45].

With the crisis profoundly affecting orthopaedic surgeons' ability to deliver care, in March 2003 the American Academy of Orthopaedic Surgeons Board of Directors approved use of $1 million in a restricted fund to begin a medical liability reform initiative. The AAOS made a total organizational commitment to the effort. The goal of the initiative was to achieve meaningful medical liability reform primarily at the federal level, and at the state level to achieve meaningful, constitutionally sustainable, state medical liability reform. A fund-raising campaign was begun as was a total organizational communications effort. The AAOS worked along with state orthopaedic societies and the Board of Councilors to monitor the status on the state level so as to help state orthopaedic associations whenever possible fight the state-level battle. The Academy's Medical Liability Committee awarded more than 14 financial grants to state orthopaedic societies to be used in conjunction with statewide efforts to either achieve or maintain medical liability reform.

With the help of these grants, eight states achieved some medical liability reform between the years 2003 and 2005. It is clear, however that state liability reform is always at risk. Wisconsin, always viewed as a stable state, had a cap on noneconomic damages, which existed for many years. In July 2005 the state's cap on noneconomic damages was declared unconstitutional by the state's Supreme Court. Within months, a Wisconsin jury awarded an $8.4 million verdict, including $4.25 million in pain and suffering damages [52]. The state legislature acted quickly and by March 2006 had capped pain and suffering awards at $750,000. However, shortly thereafter, the president of the Wisconsin Academy of Trial Lawyers vowed to challenge the new limit in court. Currently several other states that had enacted medical liability reform have been under attack in court challenges (Louisiana, Illinois, New Mexico, and most recently Texas).

On the federal front, President George W. Bush, a strong supporter of medical liability reform, asked Congress in his final State of the Union message (2008) to end frivolous lawsuits and to pass federal medical liability reform [13].

Public opinion has always favored medical liability reform. The public has always been very aware that the medical liability crisis was affecting their access to healthcare and contributing to rising costs. A Consumer Reports poll conducted in November 2007 showed that 69% of Americans believe that frivolous lawsuits were raising their healthcare costs [49]. A Health Coalition on Liability and Access Harris Interactive poll in April 2006 showed that 75% of those surveyed said they wanted their elected representatives in Washington to support comprehensive medical liability reform. Seventy-four percent of the people surveyed believe their access to affordable, high-quality healthcare is threatened because medical liability costs are forcing doctors out of medicine [43]. Americans strongly support (76%) full payment for lost wages and medical expenses and reasonable limits on awards for noneconomic pain and suffering. Sixty-seven percent of those polled favor a law to limit the fees personal injury lawyers can take from an award or settlement, and a strong majority (64%) of poll participants said medical liability lawsuits are one of the primary reasons behind rising healthcare costs [39].

The U.S. House of Representatives had passed the HR 5 Act twice in the 108th Congress and again in the 109th Congress. In fact, the House of Representatives had passed medical liability reform based on the California MICRA Legislation at least eight times in previous years. The main obstacle to federal medical liability reform has been the U.S. Senate. In the 109th Congress, four votes on medical liability reform all failed because of inability to get the 60 votes needed in the Senate to close debate. Of the 42 Senators voting against cloture, 40 were Democrats and two Republicans; all 48 votes for cloture were from Republicans (10 of the 100 senators did not vote) [47]. All proposals put forward have been modeled on the California MICRA legislation or the more recent 2003 Texas model, both of which impose varying caps on noneconomic damages.

The main opponent in this struggle for medical liability reform is the American Association for Justice, formerly known as the Association of Trial Lawyers of America. They are well-financed and have many "horror stories" of patients harmed by medical error. They use the Institute of Medicine report, "To Err is Human", to claim that 98,000 Americans die each year due to medical negligence [16]. The IOM report showed that between 44,000 and 98,000 patients may die each year due to preventable medical errors, mostly system errors, not individual physician medical negligence.

In 2003 the American Academy of Orthopaedic Surgeons, along with the American Academy of Neurological Surgeons, formed Doctors for Medical Liability Reform (DMLR). At its inception, DMLR included the American Academy of Orthopaedic Surgeons, American Association of Neurological Surgeons, American College of Emergency Physicians, American College of Surgeons, American College of Obstetrics-Gynecology, American College of Cardiology, American Dermatology Association, American Urologic Association, American Society of Plastic Surgery, and the North American Spine Society. The coalition represented more than 220,000 physicians.

The goal of DMLR is to educate and inform patients, physicians, business leaders, and legislators about the destructive effects that the medical liability crisis is having on the nation's healthcare and the nation's economy. DMLR was and is currently a purely public information and education organization.

In the 2004 election, DMLR hoped to use its educational message to affect key senate races in play that year. The primary tool for DMLR's educational effort was a televised 30-minute news magazine airing in and around prime time in targeted states where key Senate races were in play. Every candidate for federal office had to declare his position on the issue by signing (or not) the DMLR pledge for medical liability reform.

DMLR spent $10 million and was able, through its educational programs, to contribute to the election of senators who supported medical liability reform. For the 2005–2006 Congressional session, there were five new "yes" votes for medical liability reform in the Senate. In addition, candidates favoring medical liability reform won in six of eight open Senate races. As a result, at the beginning of the 2005–2006 legislative session, there was still a majority favoring medical liability reform in the House, and on the Senate side there were now around 55 potential "yes" votes. DMLR was optimistic that federal medical liability reform could be attained.

In 2005, President George W. Bush made tort reform, particularly medical liability, his highest priority. His first speech following his reelection on January 3, 2005, was in Madison County, Illinois, which had recently been designated a "judicial hellhole" by the American Tort Law Reform Association. (It since has been re-evaluated and dropped to a "watch list" [3].) A judicial hellhole is the term used by the American Tort Law Reform Association to designate the most unfair jurisdictions in which to be sued, based on a pattern of judgments that favor the plaintiff [3]. In that speech he highlighted the issue of the disastrous effects of the medical liability crisis on Americans' access to healthcare and increasing medical costs [9]. Congress that year had a legal reform agenda as its top priority. It started with class action reform and bankruptcy reform, which was to be followed immediately by medical liability reform. Doctors for Medical Liability Reform's

strategy for the 2005–2006 legislative cycle was to develop and build a grassroots network of concerned citizens. Our plan was to mobilize these concerned citizens in the 2006 election year. DMLR also wanted to keep medical liability reform at the forefront of the national healthcare debate, to drive traffic to the Doctors for Medical Liability Reform Web site (www.protectpatientsnow.org), and to position DMLR as the top resource on the subject to the media, Congress, the physician community, and the general public.

In 2006 DMLR mobilized to get the Senate to take a vote on the issue of medical liability reform. We knew that we did not have enough votes to gain passage, but we believed that in an election year we needed to demonstrate we had a majority of senators supporting medical liability reform, and we wanted to get all senators to declare their position on the issue.

The primary solution to the medical liability reform crisis advocated by most physician groups and the fundamental tenet of federal legislation introduced thus far is the cap on noneconomic damages. This is the only solution that has a proven track record in the United States. Caps have been proven to keep premiums down, have been shown to address the manpower needs to improve the access to healthcare, and to decrease healthcare costs [21]. In California, liability premiums rose 283% from 1976 to 2003 versus 925% for the rest of the country [50]. Oregon adopted caps on noneconomic damages in 1987. In 1998, the Oregon Supreme Court threw out the caps. Within 3 years, the cost of medical liability claims increased by 400% [6]. In 2000, the premium in California for a $1 million to $3 million policy for an obstetrician-gynecologist was $52,874, and increased in 2004 to $63,272. The same policy coverage, same specialty, and same years, in Dade County, Florida in 2000 cost $147,621 compared to $277,241 in 2004. The difference is that California has achieved and sustained meaningful medical liability reform.

Texas is another example of where caps on noneconomic damages have been successful in encouraging physicians to practice in the state. Jury awards in 1989 in Texas averaged $472,932, whereas in 1999 they increased to an average of $2 million. Thirteen carriers departed the market in Texas from 1999 to 2003, while 85% of the suits were dismissed without payment. After tort reform was constitutionally sustained in 2003, more than 3000 new doctors had come to Texas by 2005 including high-risk specialties, specialists like orthopaedic surgeons, neurosurgeons, and emergency room physicians. Twenty-two new carriers came to the state, and the Texas Medical Liability Trust had a 16.4% rate reduction. The largest carrier then announced another 5% reduction in rates, for a 22% reduction in 24 months. In addition the number of lawsuits and other medical liability filings dropped dramatically after September of 2003 [26]. Since the passage of medical liability reform, patients' access to care has increased due to an influx of needed specialists and increased access in underserved areas (Appendix 1). Insurance rates are down and the climate is conducive to improving access and decreasing healthcare costs (Appendix 1) [46].

Former CMS administrator Mark McClellan also noted a $250,000 cap on noneconomic damages in malpractice lawsuits would have a direct effect on malpractice premiums and would also have an effect on costs to consumers [14]. McClellan said that a cap would result in a 5% to 9% decrease in hospital expenditures within 3 to 5 years. The Joint Economic Committee noted that a cap on noneconomic damages would result in $19 billion in savings [32]. Another report showed that laws limiting malpractice payments lower state healthcare expenditures by 3% to 4% [24].

Physician supply is also affected by tort reform. The Agency for Healthcare Research and Quality also showed that states that have enacted limits on noneconomic damages in medical lawsuits have about 12% more physicians per capita than states without such a cap [23]. Other reports have shown similar trends [30]. The Joint Commission on Accreditation of Healthcare Organizations also reported that without a cap on noneconomic damages, patient safety is at risk because without this there could be no transparency, which is fundamental to development of patient safety [36].

Alice Rivlin, Office of Management and Budget director under President Clinton and former vice chair of the board of governors of the Federal Reserve, coauthored a Brookings Institute Study on Healthcare, in which it was observed that the medical liability crisis is real and driving insurance premiums sky high [8]. The authors also noted that "capping malpractice awards would lower the cost of malpractice insurance." They also said that "some healthcare savings would come from reducing defensive medicine."

With clear evidence of the positive effects of liability reform, the external environment profoundly changed; affecting the ability to gain federal medical liability reform. The war in Iraq, the economy, Hurricane Katrina, and many other issues became of greater concern to Americans. By 2006, President Bush, the main champion of medical liability reform, saw his approval rating continue to fall until it reached 29% just prior to the 2006 election [44]. With that election and loss of both houses of Congress, the prospect for federal medical liability reform dimmed.

As we look back on the accomplishments of DMLR after the 2006 election, it was clear that the medical liability issue had been raised in the words of one U.S. Senator "to the level of abortion" (personal communication of the author with a senator). We were able to get a vote in the Senate so as to have each Senator declare their position on the issue. We were able to position DMLR as the main resource on medical liability reform in the

Beltway. We were able to build a grassroots network of more than 700,000 individuals who could be mobilized to action. We provided the medical community with a Web site that was the "go-to" site for information on medical liability reform, and we developed a cadre of committed spokespersons for medical liability reform.

Our spokespeople reached more than 114,000,000 radio listeners in 29,000 nationally broadcast interviews (2007 Annual Report of DMLR to member organizations). We garnered more than 114,000 signed petitions in support of medical liability reform in 2006. Our grassroots network sent more than 20,000 letters to members of Congress using the Protect Patients Now interactive Web site with 15,800 of those letters going to members of the United States Senate. We redesigned and expanded the Protect Patients Now Web site, logging 653,000 page views, recording 96,403 actions taken, and drawing 276,000 unique visitors.

We also made progress in the Congress, as the issue moved from being unacknowledged to being viewed as an issue necessitating some solution. In the May 25, 2006, issue of the New England Journal of Medicine, senators Hillary Rodham Clinton and Barack Obama authored an article "Making Patient Safety the Centerpiece of Medical Liability Reform." In that article they stated "the current tort system does not promote open communications to improve patient safety. On the contrary, it jeopardizes patient safety by creating an intimidating liability environment" [15].

In 2007 and 2008, the crisis of access to care, increasing healthcare costs, and changing doctor/patient relationships continues to escalate. It has been estimated that the nation's tort system imposes a yearly tort tax of $9,827 for a family of four and raises healthcare spending in the United States by $124 billion [35]. The average obstetrician delivers 100 babies per year. If the medical liability premium to practice obstetrics is $200,000 (as it is in Florida), a mother pays an additional $2000 to deliver her baby just to pay for the cost of the medical liability crisis [1]. This does not include any indirect costs that result from defensive medicine or decreased access to timely care.

Various crisis situations are in play around the country that will further impact access to care. The current issues in New York State have previously been discussed. In Oregon, a medical liability lawsuit ruling threatens to add $30 million in insurance and administrative expenses. The Oregon Health Science University announced that as a result it will have to cut 200 to 300 jobs, raise tuition by 10% to 25%, and restructure or close scores of clinical, research, and education programs [48]. A recent Massachusetts ruling that a doctor can be sued over a car accident caused by his patient potentially expands physician liability to unprecedented levels [31].

Currently, despite the fact that caps on noneconomic damages are the only solution with a proven track record in the United States, with the current makeup of the U.S. Congress this will not be an alternative. Other options we are working to bring to legislative and public attention include a "loser pays" system similar to that of the United Kingdom, courts specializing in healthcare litigation, a no-fault (worker's compensation) model, and Early Offer. America differs from all other Western democracies, indeed from virtually all nations, in its refusal to recognize the principle that the losing party in litigation should contribute toward the losses incurred by its prevailing opponent; this concept is called "loser pays" and it is believed to discourage frivolous lawsuits. Specialty courts are not new in the United States, and it is possible that creating special courts to adjudicate medical malpractice claims may be an improvement on the present system. Mental health courts, for example, exist in the United States to deal with crimes in a way that addresses the person's mental health needs. An "early offer" system allows a party facing a personal injury lawsuit, such as for medical malpractice, to promptly pay the injured party for out-of-pocket medical expenses and lost wages while avoiding the high costs of litigation.

In 2007 and 2008 DMRL's goals are to advance medical liability reform as a key issue in the public debate on healthcare; maintain DMLR's position as the top resource for medical liability reform; and preserve and expand the grassroots network. We will continue educating key decision makers and opinion leaders and new members of congress as well as presidential candidates. We have held numerous briefings, prepared a primer on access-to-care issues; continued to enhance the DMLR Web site with fact sheets, news articles, and key research studies; and addressed each report from opponents of liability reform with factual retort. We also have been trying to mobilize our DMRL grassroots network to help on the state level. We will be hosting a healthcare conference this fall (America's Healthcare at Risk, http://healthcareatrisk.org) on the broader issues of healthcare and ensure that the medical liability crisis is taken into consideration in all proposed solutions [4]. We will continue to work with individuals and groups who realize that any solution to the healthcare issues facing Americans must address one of the major issues affecting access to care and rising healthcare costs.

Appendix 1

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Proposition 12 Produces Healthy Benefits

Improving access to medical care is critically important to all Texans

- This is especially true for children, pregnant women, the aged, the poor, those in an emergent condition and those in rural Texas.

Charity care has greatly increased since the passage of the 2003 reforms

- Charity care rendered by Texas hospitals rose 24% in the three years following the passage of Prop. 12. But for the 2003 reforms, this $594 million increase in charity care expenses would have left many Texas hospitals with the stark choice of turning away charity care patients or closing their doors altogether. The state's non-profit hospitals saw their charity care costs increase 36% in this same time frame.

HB 4 (the 2003 medical liability reforms) has a track record of improving access to medical care

- Texas licensed a record 3324 new doctors this year; 808 more than last year.
- Since the passage of the 2003 reforms, the state has improved its national standing from 48th to 42nd in the American Medical Association's measurement of patient-care doctors per capita.
- The physician growth rate in El Paso is 76% greater than pre-reform.
- The physician growth rate in San Antonio is 55% greater than pre-reform.
- The physician growth rate in Houston is 36% greater than pre-reform.

After years of decline, the ranks of medical specialists are growing

- After a net loss of 14 obstetricians from 2001 to 2003, Texas experienced a net gain of 186 obstetricians.
- Texas experienced a net loss of nine orthopedic surgeons from 2000 to 2003. Since tort reform, the state experienced a net gain of 156 orthopedic surgeons.
- Texas has experienced a net gain of 26 neurosurgeons since Prop 12, including one each in the medically underserved communities of Corpus Christi and Beaumont.
- If the pending applicants are approved, the statewide total of pediatric intensive care, pediatric emergency medicine and pediatric infectious disease specialists will double.

Doctors are bringing critical specialties to underserved areas

- Since the passage of reforms, the Rio Grande Valley has added 189 physicians. That represents a robust 16.6% increase in Cameron County and an even greater 17.9% increase in Hidalgo County; both growth rates exceeding the state average.
- Jefferson, Nueces and Victoria counties saw a net loss of physicians in the eighteen months prior to tort reform. Currently, all three counties are producing impressive gains; adding much-needed specialists and emergency medicine physicians.

Hospitals are upgrading equipment, expanding their emergency rooms, launching patient safety programs and expanding their level of charity care

- Monies have also been freed to expand outpatient services, improve salaries for nurses and increase payment to on-call physicians.

Premiums are stable and reduced

- All major physician liability carriers in Texas have cut their rates since the passage of the reforms, most by double-digits. Texas physicians have seen their liability rates cut, on average, 24.3%. Two-thirds of Texas doctors have seen their rates slashed a quarter or more.
- Seventeen rate cuts have occurred in Texas since the passage of the 2003 landmark reforms.

Reductions in premiums since the passage of Prop. 12 and respective savings:

- Texas Medical Liability Trust: 31.3%, and $200 million in savings plus three renewal dividends totaling an additional $75 million.
- APIE: 17.4%, and $14.8 million in savings
- Medical Protective: 25.7%, and $12.6 million in savings
- Joint Underwriting Association (JUA):10%, and $6 million in savings)

- The Doctors Company, 25.3%, and $4.2 million in savings
- Advocate MD: 29.5%, and *$5.34* million in savings

Cumulative liability cost savings since January, 2004: $327.94 million.

- Roughly half of the state's doctors are now paying lower liability premiums than they were in 2001.

Competition in the Health Care Liability Market Increasing

Since the passage of Proposition 12, Texas has added:

- Four new admitted, rate-regulated carriers: Advocate MD of the Southwest, Medical Liability Insurance Company of America, Medicus Insurance Company and the Physicians Insurance Company.
- Twenty six risk retention groups, captives, surplus lines and other unregulated insurers.
- Texas physicians can competitively shop their policies.
- Thirteen percent of the commercial physician liability market is being insured by companies new to Texas since February 2003.

Claims and lawsuits in most Texas counties have been cut in half

Changing HB 4 will hurt access to medical care.

- CHRISTUS Spohns' Westside Corpus Christi clinic serving the indigent and its Diabetes Excellence Program are funded by the hospital's medical liability savings. Take away the savings and the programs are jeopardized.
- Driscoll Children's Hospital in Corpus Christi used its liability savings to open satellite clinics in the border cities of Brownsville and McAllen. Take away the savings and the programs are jeopardized.
- Kelsey-Seybold Clinic in Houston is using its liability savings to fund an electronic medical record. This electronic medical record will eliminate sources of medical error due to illegibility, monitor for medication allergies and alert the prescribing physician about drug interactions. It will also allows results to be graphed to show doctor and patient trends over time and will reduce the cost of health care through more efficient handling of medical information. This $20 million electronic medical record investment would not be possible without the savings achieved by medical liability reform. Kelsey-Seybold treats 1.1 million patient visits a year in the Houston area.

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